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Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, *et al.*,
Intervenors / Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICI CURIAE* SOCIETY FOR HUMAN RESOURCE MANAGEMENT, NATIONAL FEDERATION OF INDEPENDENT BUSINESS SMALL BUSINESS LEGAL CENTER, AND NATIONAL ASSOCIATION OF MANUFACTURERS IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTERESTS OF THE AMICI CURIAE 1

SUMMARY OF ARGUMENT 3

ARGUMENT 4

CONCLUSION 25

TABLE OF AUTHORITIES

Page(s)

CASES

Alessi v. Raybestos-Manhattan, Inc.,
451 U.S. 504 (1981) 2

Brown v. Ampco-Pittsburgh Corp.,
876 F.2d 546 (6th Cir. 1989) 13

Brundage-Peterson v. Compcare Health Services Ins. Co.,
877 F.2d 509 (7th Cir. 1989) 9

Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.,
809 F.2d 617 (9th Cir. 1987) 8, 9

Deibler v. United Food & Commercial Workers' Local Union 23,
973 F.2d 206 (3d Cir. 1992) 12, 13

Donovan v. Dillingham,
688 F.2d 1367 (11th Cir. 1982) 9, 12, 13, 14

Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.,
805 F.2d 732 (7th Cir. 1986) 13

Elmore v. Cone Mills Corp.,
23 F.3d 855 (4th Cir. 1994) (*en banc*) 13

Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987) 10

Golden Gate Restaurant Association v. City and County of San Francisco, 535 F.Supp.2d 968 (N.D. Cal. 2007) 20

Golden Gate Restaurant Association v. City and County of San Francisco, 546 F.3d 639 (9th Cir. 2008) ..... passim

Golden Gate Restaurant Association v. City and County of San Francisco, 558 F.3d 1000 (9th Cir. 2009) 4, 18

Grimo v. Blue Cross/Blue Shield of Vermont, 34 F.3d 148, (2d Cir. 1994) 9

Gruber v. Hubbard, 159 F.3d 780 (3d Cir. 1998) 8

Guilbert v. Gardner, 480 F.3d 140 (2d Cir. 2007) 12

Harris v. Arkansas Book Co., 794 F.2d 358 (8th Cir. 1986) 13

Int'l. Association of Entrepreneurs v. Foster, 883 F. Supp. 1050 (E.D. Va. 1995) 15

Inter-Modal Rail Employees Ass'n. v. Atchison, Topeka & Santa Fe Ry., 520 U.S. 510 (1997) 19

Kenney v. Roland Parson Contracting Corp., 28 F.3d 1254 (D.C. Cir. 1994) 8, 13

Kidder v. H & B Marine, Inc., 932 F.2d 347 (5th Cir. 1991) 9

Madonia v. Blue Cross & Blue Shield of Virginia,
11 F.3d 444 (4th Cir. 1993) 8, 9

Massachusetts v. Morash,
490 U.S. 107 (1989) 10

Memorial Hospital System v. Northbrook Life Ins. Co.,
904 F.2d 236 (5th Cir. 1990) 3

Patelco Credit Union v. Sahni,
262 F.3d 897 (9th Cir. 2001) 10

Peckham v. Gem State Mut.,
964 F.2d 1043 (10th Cir. 1992) 8, 13

Postma v. Paul Revere Life Ins.,
223 F.3d 533 (7th Cir. 2000) 9

Randol v. Mid-West Nat'l Life Ins. Co.,
987 F.2d 1547 (11th Cir.1993) 9

Retail Industry Leaders Ass'n v. Fielder,
475 F.3d 180 (4th Cir., 2007) .....passim

Robinson v. Linomaz,
58 F.3d 365 (8th Cir. 1995) 8, 9

Sandstrom v. Cultor Food Science, Inc.,
214 F.3d 795 (7th Cir. 2000) 13, 14

Scott v. Gulf Oil Corp.,
754 F.2d 1499 (9th Cir. 1985) 13

Shaw v. Delta Air Lines, Inc.,
463 U.S. 85 (1983) 18

Sipma v. Massachusetts Casualty Ins. Co.,
256 F.3d 1006 (10th Cir. 2001) 9

Wickman v. Northwestern National Ins. Co.,
908 F.2d 1077 (1st Cir.1990) 9, 12

Winterrowd v. Am. Gen. Annuity Ins. Co.,
321 F.3d 933 (9th Cir. 2003) 13

STATUTES

§ 105 of the Internal Revenue Code, 26 U.S.C.
§ 105 19

Title I of the Employee Retirement Income
Security Act of 1974, 29 U.S.C. §§ 1001 *et*
seq. ..... passim

ERISA § 3(1), 29 U.S.C. § 1002(1) ..... passim

ERISA § 3(2), 29 U.S.C. § 1002(2) ..... passim

ERISA § 3(3), 29 U.S.C. § 1002(3) 15

ERISA § 4(a), 29 U.S.C. § 1003(a) 15

ERISA § 4(b)(3), 29 U.S.C. § 1003(b)(3) 14

ERISA § 502, 29 U.S.C. § 1132 15

ERISA § 514, 29 U.S.C. § 1144 6

ERISA § 514(a), 29 U.S.C. § 1144(a) ..... passim

ERISA § 601, 29 U.S.C. § 1161, et seq. 15

ERISA § 601(b), 29 U.S.C. § 1161(b) 3

ERISA § 607(1), 29 U.S.C. § 1167(1) 15, 16

ERISA § 701(f), 29 U.S.C. § 1181(f) 21, 22

42 USC § 1397ee(c)(10)(A), as added by Pub. Law 111-3, Tit. III, Subtitle A, § 301(a)(1) (Feb. 4, 2009) 21, 22

Children's Health Insurance Program Reauthorization Act of 2009, Pub. Law 111-3 (Feb. 4, 2009) 21

Children's Health Insurance Program Reauthorization Act of 2009, Pub. Law 111-3, Title III, Subtitle B, § 311(b)(1)(A) (Feb. 4, 2009) 2

Children's Health Insurance Program Reauthorization Act of 2009, Pub. Law 111-3, Title VI, Subtitle C, § 622(b)(3) (Feb. 4, 2009) 21

American Recovery and Reinvestment Act of 2009, Pub. L. 111-5 (Feb. 17, 2009) 22

American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, Title III, § 3001(a)(1) (Feb. 17, 2009) 22

STATE STATUTES AND REGULATIONS

Maryland's Fair Share Health Care Fund Act, 2006 Md. Laws 1, Maryland Code

Annotated, Labor & Employment. §§ 8.5-101 to 107 (2006) 16, 17

Maryland Code Annotated, Health-Gen. § 15-142(f) 17

CITY AND COUNTY STATUTES AND REGULATIONS

San Francisco Health Care Security Ordinance §§ 14.1 *et seq.* (2007) 4, 23

San Francisco Health Care Security Ordinance § 14.1(b)(7)(e) 6

San Francisco Health Care Security Ordinance § 14.3(a) 6, 8

Regulations Implementing Healthy San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance ("Plan Regulations"), § 4.1(A) 6

Regulations Implementing Healthy San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance ("Plan Regulations"), § 7(c) 6

OTHER AUTHORITIES

Supreme Court Rule 37.6 1

29 C.F.R. § 2510.3-1(b)(3)(i) 11

29 C.F.R. § 2510.3-1(b)(3)(iv) 11

29 C.F.R. § 2510.3-1(k) 11, 12

ERISA Opn. Ltr. 77-90 11

ERISA Opn. Ltr. 94-14 (April 20, 1994) 11

ERISA Opn Ltr. 96-25 (Oct. 31, 1996) 9, 10

Roundtable to Discuss Reforming America's Health Care Delivery System: Hearing Before S. Committee on Finance, 111th Cong. (April 21, 2009), available at http://finance.senate.gov/sitepages/hearing042109.htm 21

Statement of John J. Castellani, President, Business Roundtable, speaking before the Senate Finance Committee during a roundtable discussion on healthcare coverage on May 5, 2009, available at http://finance.senate.gov/sitepages/hearing050509.html. 20

Roundtable Discussion on "Expanding Health Care Coverage": Hearing Before S. Committee on Finance, 111th Cong. (May 12, 2009), available at http://finance.senate.gov/sitepages/hearing050509.html. 21

HRET/Kaiser Family Foundation, 2008 Employer Health Benefits Survey, http://ehbs.kff.org/pdf/7790.pdf. 20

M. S. Gordon, *Introduction: The Social Policy Origins of ERISA*, in Employee Benefits

Law (S.J. Sacher and J.I. Singer, eds., ABA, 2d ed. 2000) at xc-cii 24

Pension and Benefits Reporter, vol. 36, No. 20 (BNA) (May 19, 2009) 19

E.A. Zelinsky, *'Golden Gate Restaurant Association' Employer Mandates and ERISA Preemption in the Ninth Circuit*, Cardozo Legal Studies Research Paper No. 219, 23-28 (2008) available at http://ssrn.com/abstract=1090122 5

E.A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 Cardozo L.Rev. 847, 869 (2006) 19

J.A. Wooten, *A Legislative and Political History of ERISA Preemption, Part I*, 14 J. of Pension Benefits 10 (2006) 25

INTERESTS OF THE AMICI CURIAE

Amicus National Federation of Independent Business Small Business Legal Center ("NFIB Legal Center"), is a nonprofit, public interest law firm and is the legal arm of the National Federation of Independent Business ("NFIB"). NFIB is the nation's leading small business association, representing about 350,000 small businesses throughout the United States. *Amicus* Society for Human Resource Management ("SHRM") is the world's largest association devoted to human resource management, representing more than 250,000 individual members in over 140 countries and with more than 575 affiliated chapters in the United States. *Amicus* the National Association of Manufacturers ("NAM") is the nation's largest industrial trade association, representing small and large manufacturers in every industrial sector and in all 50 states.[1]

Two long-standing interests of the *Amici* are put in jeopardy by the decision of the Court of Appeals in this case: (1) preserving the exclusivity of federal

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[1] *Amici Curiae* NFIB Legal Center, SHRM, and NAM (collectively, "the *Amici*") have obtained the written consent of all the parties to file this brief with the Court. Pursuant to Supreme Court Rule 37.6, the *Amici* note that counsel for *Amici* wrote the entirety of this brief and that no person or entity, other than the *Amici*, their members, or their counsel, made a monetary contribution to the preparation or submission of this brief. The parties were notified more than ten days prior to the due date of this brief of the intention to file.

regulatory authority over employee benefit plans subject to Title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA" or "the Act"), that this Court recognized over twenty-five years ago in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981); and (2) restoring the long-established judicial and regulatory consensus that any recurring process adopted by an employer to pay or provide in advance for health care coverage for its employees is an "employee welfare benefit plan" as defined in Section 3(1) of ERISA.

BRIEF OF *AMICI CURIAE* NATIONAL FEDERATION OF INDEPENDENT BUSINESS SMALL BUSINESS LEGAL CENTER, NATIONAL ASSOCIATION OF MANUFACTURERS, AND SOCIETY FOR HUMAN RESOURCE MANAGEMENT IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

SUMMARY OF ARGUMENT

The petition for *certiorari* should be granted for three reasons.

First, the Ninth Circuit ruled that a private employer does not "establish[] or maintain[]" an employee welfare benefit plan within the meaning of those terms as used in Section 3(1) of ERISA when it makes regular, periodic payments in determinable amounts to pay for health coverage for its employees under programs established by a municipal ordinance. *See Golden Gate Restaurant Association v. City and County of San Francisco,* 546 F.3d 639, 646-47, 649-653 (9th Cir. 2008) ("*GGRA II*"). In reaching this conclusion, the Ninth Circuit departed from an essentially unanimous body of prior case law and regulatory guidance regarding what constitutes establishing or maintaining a plan. Thus, the decision in this case creates fundamental doubt over the applicability of Title I of ERISA as a whole, including its broad preemption provision, ERISA § 514(a).

Second, the Ninth Circuit's decision in this case is in direct conflict with the Fourth Circuit's decision in *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180, 196 (4th Cir., 2007) ("*RILA*"), regarding the application of ERISA § 514(a) to state and local "pay or play" laws. *See Golden Gate Restaurant Association v. City and County of San Francisco*, 558 F.3d 1000, 1006-07 (9th Cir. 2009) (M. Smith, Circuit Judge, dissenting from denial of petition for rehearing *en banc*) ("*GGRA III*"). The Court should grant the petition to resolve that conflict because its continuation will have immediate practical implications for employers that sponsor group health plans for their employees both within and outside the Ninth Circuit.

Third, the need to resolve the uncertainties created by the Ninth Circuit's decision in this case is especially urgent in light of the high priority the President and Congress have given to enacting comprehensive health care reform this year. Both the conflict between *GGRA II* and *RILA* over the application of ERISA § 514(a) and the more general uncertainty about what constitutes the establishment or maintenance of a welfare benefit plan are potential obstacles to adopting uniform federal health care reform legislation.

ARGUMENT

I. The Ninth Circuit held that ERISA does not preempt the health care spending requirement of the San Francisco Health Care Security Ordinance, as amended, San Francisco Administrative Code §§ 14.1 *et seq.* (2007) ("the Ordinance"). *GGRA II*, 546 F.3d

at 642. The Court of Appeals concluded that the spending mandate does not require a covered employer to adopt or amend an ERISA-governed plan. *Id.*, 546 F.3d at 646. The court reasoned that the "City-payment option . . . allows employers to make payments directly to the City . . . without requiring them to establish, or to alter existing, ERISA plans." *Id.* In support of this conclusion, the Ninth Circuit held that "An employer electing the City-payment option does not 'establish[] or maintain[]' the HAP [the City-administered plan] through its payments." *Id.*, 546 F.3d at 653 (*citing and quoting* ERISA Section 3(1), 29 U.S.C. § 1002(1), defining "welfare benefit plan").

The Ninth Circuit was profoundly mistaken in holding that an employer's election of the "City-payment option" does not entail the employer's establishment or maintenance of an ERISA plan, as the leading academic authority on ERISA preemption has pointed out. *See* E.A. Zelinsky, "'*Golden Gate Restaurant Association' Employer Mandates and ERISA Preemption in the Ninth Circuit*," Cardozo Legal Studies Research Paper No. 219, 23-28 (2008), available at http://ssrn.com/abstract=1090122. More significantly, the Ninth Circuit's mistake in this regard is not the result of misapplying established law to unusual facts. It is the product of a complete departure from existing law and regulatory guidance.

A. San Francisco's Ordinance has two primary components: a quarterly employer health care spending requirement, and a City-administered health care program. *GGRA II*, 546 F.3d at 642-43.

The employer spending provisions of the Ordinance mandate that covered employers make "required health care expenditures to or on behalf of" each of their covered employees each calendar quarter. Ordinance § 14.3(a); *see also GGRA II*, 546 F.3d at 643. The City-administered health program ("HAP") consists of a point-of-service arrangement ("Healthy San Francisco") and a Medical Reimbursement Account Plan. *See* Regulations Implementing Healthy San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance ("Plan Regulations"), § 7(c).

Although distinct, the employer spending requirement and the health care program components of the Ordinance are not entirely independent of each other. A "health care expenditure" is defined generally as any payment by an employer to or for the benefit of its covered employees "for the purpose of providing healthcare services to [its] covered employees or reimbursing the cost of such services to its covered employees." Plan Reg. § 4.1(A). The Ordinance defines "health care expenditure" to include payments to the City on behalf of one or more of the employer's covered employees. Ordinance, § 14.1(b)(7)(e). A payment of this kind is used to subsidize the covered employee's participation in the point-of-service arrangement (if the employee is a City resident and meets other requirements for Healthy San Francisco eligibility) or to fund a medical reimbursement account for the covered employee who does not meet the Healthy San Francisco eligibility requirements. *GGRA II, supra,*, 546 F.3d at 645. A covered employer can satisfy its spending requirement in whole or in part

by making quarterly payments in the required amounts to the City on behalf of one or more of the employer's covered employees. *Id.* Thus, when an employer chooses the "City-payment option" as a mode of compliance with the Ordinance's spending requirement, the employer's choice necessarily entails providing its employees prospectively with health care coverage on a programmatic basis through regular periodic payments that are made to a third party (the City) and used exclusively to provide medical coverage to those employees. *GGRA II*, 546 F.3d at 649-650.

B. On these facts, the Ninth Circuit concluded that "An employer electing the City-payment option does not 'establish[] or maintain[]' the HAP through its payments." *GGRA II*, 546 F.3d 653. The Court of Appeals cited no authority to support this conclusion, which is completely at odds with the statutory language, long-standing regulatory guidance, and a substantial body of case law.

Section 3(1) defines the term "employee welfare benefit plan" to include

> *any* plan, fund, or program . . . established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance *or otherwise* . . . medical, surgical, or hospital care or benefits . . . .

It has long been recognized that the degree of employer involvement necessary to trigger the application of this definition is minimal. As the Ninth Circuit itself observed more than two decades ago, "An employer . . . can establish an ERISA plan rather easily." *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987). The statutory requirement that a plan be "established or maintained" by an employer has been interpreted merely to require that plan coverage is "part of an employment relationship." *Peckham v. Gem State Mut.*, 964 F.2d 1043, 1049 (10th Cir. 1992). *See also, Kenney v. Roland Parson Contracting Corp.*, 28 F.3d 1254, 1259 (D.C. Cir. 1994). Here, the Ordinance itself provides the necessary assurance that an employer choosing the City-payment option does so to fulfill an obligation to a covered employee in his or her capacity as such. Ordinance § 14.3(a).

Furthermore, an employer's election of the City-payment option is a deliberate choice to pay a third party to provide medical coverage for its employees. *GGRA III*, 558 F.3d at 1002. That fact alone is a sufficient basis on which to find that the employer "established" a plan subject to ERISA. *See, e.g., Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444 (4th Cir. 1993). Indeed, every Court of Appeals that seems to have considered the question has determined that the employer's payment of policy premiums or plan contributions for its employees' health coverage is "evidence" or "substantial evidence" that the employer established or maintained a welfare benefit plan. *Gruber v. Hubbard*, 159 F.3d 780, 789 (3d Cir. 1998); *Robinson*

v. Linomaz, 58 F.3d 365, 368 (8th Cir. 1995); *Madonia, supra*, 11 F.3d at 447; *Randol v. Mid-West Nat'l Life Ins. Co.*, 987 F.2d 1547, 1551 (11th Cir. 1993); *Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509, 511 (7th Cir. 1989); *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co., supra*, 809 F.2d at 625; *Sipma v. Massachusetts Casualty Ins. Co.*, 256 F.3d 1006, 1012 (10th Cir. 2001) (substantial evidence of establishment); *see also, Postma v. Paul Revere Life Ins.*, 223 F.3d 533, 537 (7th Cir. 2000) ("An employer establishes or maintains a plan if it enters a contract with the insurer and pays its employees' premiums.") (citation omitted); *and cf. Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991); *Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148, 151-52 (2d Cir. 1994), *and Wickman v. Northwestern National Insurance Co.*, 908 F.2d 1077, 1083 (1st Cir. 1990), *each citing and quoting Donovan v. Dillingham,* 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*) ("the purchase of a group policy or multiple policies covering a class of employees offers substantial evidence that a plan, fund, or program has been established"). Thus an employer's implementation of a decision to make payments under the "City-payment option" clearly falls within the literal terms of the statutory definition of a welfare benefit plan, as reflected in the consensus of the Courts of Appeals.[2]

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[2] It is immaterial that the third-party recipient of the premiums in this case was created by municipal law and is open to numerous employers. "If an employer adopts for its employees a program of benefits sponsored by a group or association that does not itself constitute an 'employer' or an 'employee organization,' such an employer or employee organization may

C. Thus the question Petitioner seeks to present does not arise from a debatable application of settled law. It results from subverting and supplanting established law. This conclusion is evident from two of the bases on which the decision suggests that the City-payment option does not result in the establishment or maintenance of an employee benefit plan as a matter of law.

1. The Ninth Circuit concluded that if an employer's regular periodic payments of cash in an amount calculated based on the number of hours worked by the employee does not constitute an employee benefit plan under *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16, (1987), and *Massachusetts v. Morash*, 490 U.S. 107, 109 (1989), then *a fortiori* the regular periodic payment under the Ordinance of the same amount, calculated on the same basis, to the City for the employee's benefit rather than to the employee directly does not constitute an employee benefit plan. *GGRA II*, 546 F.3d at 649-50.

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have established a separate, single-employer (or single employee organization) employee benefit plan covered by Title I of ERISA." ERISA Opn. Ltr. 96-25 (Oct. 31, 1996). *See also Patelco Credit Union v. Sahni*, 262 F.3d 897, 907-08 (9th Cir. 2001) ("[W]hether a multi-employer welfare arrangement itself is an employee welfare benefit plan is a separate question from whether an employer subscribing to a multi-employer welfare arrangement has established an ERISA employee welfare benefit plan vis-a-vis its own employees.")

This conclusion is quite literally the opposite of the conclusions reached by the Department of Labor in a body of regulatory guidance stretching back nearly thirty-five years. According to that guidance, an employer's payment to a third party for the benefit of its employee *causes* certain otherwise non-covered arrangements to be subject to ERISA. *See, e.g.*, ERISA Opn. Ltr. 77-90 (April 25, 1977) ("[a] vacation benefit account established pursuant to a collective bargaining agreement" under which "[e]ach contributing employer makes a payment to [an employers' association] based upon the number of hours credited to that employer's employees covered by the agreement" does not fall within the exemption under 29 C.F.R. § 2510.3-1(b)(3)(i) because the employer's association "deposits these contributions in the vacation benefit account and, pursuant to the agreement, distributes the vacation pay to the covered employees," and therefore payment is not made from an employer's general assets.); *and* ERISA Opn. Ltr. 94-14 (April 20, 1994) (payments of apprenticeship program benefits from a trust covered by ERISA, even though payments to the trust are "derived exclusively from employer contributions," in part because the benefits "are not paid from the general assets of an employer or an employee organization, as described in subsections 2510.3-1(b)(3)(iv) and 2510.3-1(k)."). *Cf.*, 29 C.F.R. § 2510.3-1(b)(3)(i) (exempting from coverage under ERISA payment of an employee's compensation during a vacation or holiday, if made from an employer's general assets); 29 C.F.R. § 2510.3-1(b)(3)(iv) (exempting from coverage under ERISA "[p]ayment of compensation on account of periods of time during which an employee performs little or no productive

work while engaged in training," but only if payment is made from the Employer's general assets); and § 2510.3-1(k) (exempting from ERISA coverage unfunded scholarship programs, *i.e.*, "scholarship program[s], including a tuition and education expense refund program[s], under which payments are made solely from the general assets of an employer or employee organization.") (August 15, 1975).

2. The second indication that the Ninth Circuit broke with established case law is that it declined to apply the well-recognized test for plan establishment first articulated by the Eleventh Circuit in *Dillingham, supra*, 688 F.2d at 1371 (11th Cir. 1982)[3] although it had followed *Dillingham* and adopted that test in the past.

The Ninth Circuit's refusal to apply the *Dillingham* test in this case is a conspicuous departure from precedent. *Dillingham* has been followed on point by every federal Court of Appeals with appellate jurisdiction over ERISA actions, including the Ninth Circuit itself. See *Wickman v. Northwestern National Ins. Co.*, 908 F.2d 1077, 1082-83 (1st Cir. 1990); *Guilbert v. Gardner*, 480 F.3d 140, 146 (2d Cir. 2007); *Deibler v. United Food &*

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[3] Under that test,

> a 'plan, fund, or program' under ERISA is established if from the surrounding circumstances a reasonable person can ascertain [1] the intended benefits, [2] a class of beneficiaries, [3] the source of financing, and [4] procedures for receiving benefits.

Id., 688 F.2d at 1373.

Commercial Workers' Local Union 23, 973 F.2d 206, 209 (3d Cir. 1992); *Elmore v. Cone Mills Corp.*, 23 F.3d 855, 861-862 (4th Cir. 1994) (*en banc*); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240-41 (5th Cir. 1990); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989); *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 738-39 (7th Cir. 1986); *Harris v. Arkansas Book Co.*, 794 F.2d 358, 360 (8th Cir. 1986); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503-04 (9th Cir. 1985); *Peckham v. Gem State Mut.*, 964 F.2d 1043, 1047-48 (10th Cir. 1992); *Kenney v. Roland Parson Contracting Corp.*, 28 F.3d 1254, 1257 (D.C. Cir. 1994). The Ninth Circuit's refusal to apply the *Dillingham* test in this case is particularly ironic given that in 1985, the Ninth Circuit became the first Court of Appeals to follow that path, *see Scott, supra*, 754 F.2d at 1503-04, and had affirmed the continued vitality of *Scott* as recently as 2003. *See Winterrowd v. Am. Gen. Annuity Ins. Co.*, 321 F.3d 933, 939 (9th Cir. 2003).

3. The revolutionary character of the law applied below is also evident from the Ninth Circuit's ostensible basis for declining to apply *Dillingham*, as it had in the past. That departure from recently re-affirmed precedent was based on nothing more than the panel's "doubt" that the *Dillingham* test should be applied "to an employer's administrative obligations imposed by a state or local law." GGRA II, at 652.[4] However, any doubt on that score had

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[4] The *GGRA II* panel also stated that it "share[d] the view expressed by the Seventh Circuit in *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795 (7th Cir. 2000)," where *in dictum* the Seventh Circuit stated that, "It is not clear that the approach

nothing to do with the precise question to be considered, which was whether the *Dillingham* test should be applied to an employer's choice of method for discharging its "administrative obligations imposed by a state or local law," not to the obligations themselves. *GGRA II*, at 652.

Furthermore, the statutory text demonstrates that there is no basis for doubt that the definition of an employee welfare benefit plan under ERISA § 3(1) encompasses plans established or maintained merely by employer contributions to provide medical benefits in compliance with state law. ERISA § 4(b)(3) provides that, subject to a handful of statutory exceptions, Title I of ERISA applies generally to all employee welfare benefit plans and employee pension benefits as defined in Sections 3(1) and 3(2) of the Act. One of those exceptions is that Title I does not apply to "any employee benefit plan . . . maintained solely for the purpose of complying with applicable workmen's compensation laws." 29 U.S.C. § 1003(b)(3). This exemption is unnecessary (and its continuous presence in the text of the statute ever since the Act was adopted in 1974 is inexplicable) if an employer's systematic payments to a state workers' compensation fund, undertaken solely for the purpose of complying with applicable

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taken in *Dillingham* is compatible with more recent decisions of the Supreme Court, which emphasize different considerations when asking whether an informal policy or arrangement is a 'plan.'" *Id. at 797* (citations omitted). Since there is nothing "informal" about the terms of the City-payment option, it is difficult to see what is the significance for this case of the doubt expressed in the *Sandstrom* dictum.

workmen's compensation laws, cannot be an employee benefit plan to begin with.

D. *GGRA II*s departure from a long-standing and virtually unanimous body of prior case law and regulatory authority is tremendously significant. The question whether a plan, fund, or program is "established or maintained" is implicated in literally every case where Title I of ERISA provides a basis for subject matter jurisdiction and/or a rule of decision. *See, e.g., Int'l. Association of Entrepreneurs v. Foster*, 883 F. Supp. 1050, 1056 (E.D.Va. 1995) & n.2 (federal court must determine whether plaintiff's plan is covered by ERISA, even if that fact is not outcome-determinative, because subject matter jurisdiction depends on it). The establishment or maintenance of a plan, fund, or program of some kind by an employer or employee organization is a prerequisite for finding that an employee benefit plan exists. *See* ERISA § 3(3) (defining "employee benefit plan" or "plan" to mean an employee welfare benefit plan or an employee pension benefit plan) *and see also* § 3(1) (defining "employee welfare benefit plan") and § 3(2) (defining "employee pension benefit plan"). The existence of an employee benefit plan is a prerequisite for the application of any provision of Title I of ERISA, including the jurisdictional provisions of Section 502, 29 U.S.C. § 1132. *See* ERISA § 4(a). Moreover, fundamental rights and guarantees such as the right to elect post-employment continuation coverage under an employer-sponsored group health plan (popularly referred to as "COBRA") depends on the establishment or maintenance of a plan. *See, gen'ly*, ERISA §§ 601 *et seq., and esp.* § 607(1) (defining

"group health plan" as a subset of employee welfare benefit plans).

II. Even if the Ninth Circuit were correct that an employer's election of the City-payment option is not the establishment or maintenance of an employee benefit plan, the *GGRA* decision directly conflicts with the Fourth Circuit's decision in *RILA* regarding the application of this Court's ERISA Section 514 jurisprudence. The very existence of that conflict creates uncertainties about the design of employee benefit plans that impinges on the ability of multi-jurisdictional employers to continue to provide employee health coverage and other benefits as they have done in the past. Given the huge percentage of Americans for whom the only source of health coverage is an employer-sponsored plan, the continuation of this uncertainty threatens a crucial component of the existing health care delivery system in the United States.

A. Despite minor variations in the surrounding facts, both *RILA* and *GGRA* rule on the same question: is a state or municipal employer health care spending mandate saved from preemption by ERISA as a matter of law merely because it includes a provision that the state or municipality characterizes as allowing an employer to comply with the spending requirement by a means other than an ERISA-governed plan?

In *RILA*, the Fourth Circuit held that ERISA § 514(a) preempted Maryland's Fair Share Health Care Fund Act, 2006 Md. Laws 1, *Md. Code Ann., Lab. & Empl.* §§ 8.5-101 to 107 (2006) ("the

Maryland Fair Share Act"), on two bases. The Maryland Fair Share Act imposed a spending requirement on a covered employer by requiring the employer to calculate the amount by which its health care expenditures for its Maryland employees fell short of 8% of its Maryland payroll, and to pay an amount equal to the shortfall to the state. Under the Maryland Fair Share Act, payments received by the state could be spent only on the Maryland Medical Assistance Program, which consisted of Maryland's Medicaid and children's health programs. 475 F.3d at 185, *citing* Md. Code Ann., Health-Gen. § 15-142(f). As Respondents are expected to do here, Maryland characterized the statute at issue in *RILA* as offering a compliance option (payments to the state) that did not require a covered employer to establish or maintain an ERISA-governed plan. 475 F.3d at 190, 194-95.

The first basis on which the Fourth Circuit held the Maryland Fair Share Act preempted by ERISA was that the Act did not offer a genuine non-ERISA alternative to complying with the minimum spending mandate, and therefore "effectively requires [covered] employers in Maryland . . . to restructure their employee health insurance plans." 475 F.3d at 183. Respondents likely will argue that *GGRA* does not conflict with *RILA* because in *GGRA*, the Ninth Circuit believed the Ordinance offered a genuine non-ERISA compliance option.

However, *GGRA* and *RILA* are in direct and irreconcilable conflict regarding the alternative basis on which the Fourth Circuit held that the Maryland Fair Share Act was preempted by ERISA. As

explained by Circuit Judge Smith in his dissent from the Ninth Circuit's denial of *en banc* review,

> The *Fielder* court explained that even were there a more "meaningful avenue" by which the employer could make non-ERISA healthcare payments, the Maryland statute was still impermissibly connected to ERISA plans. 475 F.3d at 196-97 ("If [the employer] were to attempt to utilize non-ERISA health spending options to [comply with the statute], it would need to coordinate those spending efforts with its existing ERISA plans. . . . Decisions regarding one would affect the other and thereby violate ERISA's preemption provision."). Covered employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible. *GGRA III*, 558 F.3d at 1006-07.

B. The importance of resolving this conflict is clear because it stems directly from employers' reliance on the well-established principle that state law cannot dictate benefit plan design. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 97 (1983), this Court established that for purposes of Section 514(a), a state law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *Id.* (footnote omitted). It is generally understood that under the "connection with" branch of *Shaw*, state law cannot require that an employer design a new or existing welfare benefit plan to coordinate its functions with a state law, even if the state law does not refer to the ERISA-governed plan.

Not unexpectedly, then, the conflict between *RILA* and *GGRA II* regarding "connection with" preemption under *Shaw* poses numerous practical difficulties for any business with locations in San Francisco and locations elsewhere. For example, it has been reported that such employers face difficult payroll tax and wage reporting issues that stem from having one or more self-insured health plans for employees not covered by the Ordinance and a different arrangement to comply with the Ordinance for covered employees. *Pension and Benefits Reporter*, Vol. 36, No. 20 (BNA) (May 19, 2009) (noting that such a scenario might fail to satisfy certain nondiscrimination provisions essential to favorable tax treatment of employer-provided coverage under Section 105 of the Internal Revenue Code). It is therefore essential that all parties responsible for adopting, amending, and administering those plans know as soon as possible whether and to what extent state and local law may apply either instead of or in addition to ERISA, so that they may plan accordingly.

Resolving the conflict is important at a more fundamental level, as well. ERISA's broad preemption provision was a key element by which Congress established "[a] zone of employer autonomy in the design and operation of employers' welfare plans." *See* E.A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 Cardozo L.Rev. 847, 869 (2006). *Cf. Inter-Modal Rail Employees Ass'n. v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997) (ERISA's grant of employer's freedom to amend plans prospectively encourages employer to

adopt more generous benefits at the outset). Yet, as the District Court correctly found, the Ordinance "interfere[s] with preserving employer autonomy over whether and how to provide employee health coverage." *Golden Gate Restaurant Association v. City of San Francisco*, 535 F. Supp.2d 968, 975 (N.D. Cal. 2007). Thus, the conflicting approaches in *GGRA II* and *RILA* to the "connection with" branch of this Court's ERISA Section 514(a) preemption case law creates an obstacle to the continuation and growth of employer-sponsored group health plans, particularly where the employer has employees both within and outside the Ninth Circuit.

Removing this obstacle is an urgent matter because employment-based coverage is the predominant method for providing health coverage in the United States. Almost 133 million Americans currently obtain health coverage through plans maintained by employers in the private sector. *See* Statement of John J. Castellani, President, Business Roundtable, speaking before the Senate Finance Committee during a roundtable discussion on healthcare coverage on May 5, 2009, available at http://finance.senate.gov/sitepages/hearing050509.html. Sixty-two percent of Americans under age 65 receive health benefits through their employers or a family member's employer. *See, HRET/Kaiser Family Foundation, 2008 Employer Health Benefits Survey*, http://ehbs.kff.org/pdf/7790.pdf.

III. The uncertainty engendered by the decision in this case is especially problematic because of when it arose—*i.e.*, on the eve of a national consensus that the federal government must devise a comprehensive

solution to the widespread lack of affordable health coverage. *See* Roundtable to Discuss Reforming America's Health Care Delivery System: Hearing Before S. Committee on Finance, 111th Cong. (April 21, 2009), available at http://finance.senate.gov/sitepages/hearing042109.htm; and Roundtable Discussion on "Expanding Health Care Coverage": Hearing Before S. Committee on Finance, 111th Cong. (May 12, 2009), available at http://finance.senate.gov/sitepages/hearing050509.html. Unless that uncertainty is resolved by this Court, it will impede Congress's ability to arrive at a workable solution.

A. Employer-provided health coverage is so entrenched as part of our current system that any reform of health care coverage in the United States inevitably will involve employer-sponsored group health plans covered by Title I of ERISA, at least as a transitional measure. This conclusion is evident from both of the reform measures adopted by the 111th Congress to date, each of which uses ERISA-governed group health plans as vehicles for providing coverage to those who otherwise might be uninsured.

The Children's Health Insurance Program Reauthorization Act of 2009, Pub. Law 111-3 (Feb. 4, 2009) ("CHIPRA"), authorizes states to offer federally funded premium subsidies to defray the cost of covering targeted low-income children under certain group health plans maintained by their parents' employers. *See* 42 USC § 1397ee(c)(10)(A), as added by Pub. Law 111-3, Tit. III, Subtitle A, § 301(a)(1) (Feb. 4, 2009). CHIPRA also amended Section 701(f) of ERISA to require employer-

sponsored group health plans to provide special enrollment rights based on changes in eligibility for the premium subsidies, and to require employers to give employees written notice of the potential opportunity for premium subsidies in the states in which the employees reside. Pub. Law 111-3, Tit. III, Subtitle B, § 311(b)(1)(A).[5]

The American Recovery and Reinvestment Act of 2009, Pub. L. 111-5 (Feb. 17, 2009) ("ARRA"), requires employer-sponsored group health plans, including those governed by ERISA, to treat "assistance eligible individuals" who pay 35% of a plan's monthly premium for continued post-employment coverage as if they had paid 100% of the required monthly premium under specified conditions. ARRA, Title III, § 3001(a)(1). Prior to the ARRA, federal law did not impose continuation coverage requirements on group health plans sponsored by relatively small employers, leaving the

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[5] CHIPRA also includes an affirmation of the Senate's intention to enact legislation in 2009 that "improves access to affordable and meaningful health insurance coverage for *employees of small businesses* and individuals by . . . facilitating pooling mechanisms, *including pooling across state lines*; and *providing assistance to small businesses* and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage." *Id.*, § 622(b)(3) (emphases added). The linkage between financial assistance to small businesses and improving the insurance opportunities of the employees of small business demonstrates a commitment to the continued use of ERISA-governed plans as instruments of coverage reforms. The commitment to pooling across state lines demonstrates that Congress continues to think, as it has since 1974, that state laws which could impede the continued vitality of employer-sponsored plans should be displaced by federal law.

matter entirely to state law. ERISA § 601(b), 29 USC § 1161(b). By contrast, the premium subsidy provisions of ARRA apply to employer-sponsored group health plans that are required by state law to provide post-employment continuation coverage.

Similarly, other federal initiatives currently under consideration also would act through employer-provided group health plans to change how health care is financed and provided in the United States. For example, the initial drafts of the "Affordable Health Choices Act" proposed by the Senate Health, Education, Labor and Pensions ("HELP") Committee in June 2009, would amend ERISA to prohibit pre-existing condition exclusions, abolish limits on annual or lifetime benefits, extend to 26 the age at which a dependent may be covered, limit which employers may adopt self-insured plans, and mandate employers cover employees or pay a penalty.

B. Continued uncertainty about the scope of state and municipal authority to mandate employer-sponsored health care expenditures is an impediment to reaching a resolution on national health care reform. If state and local governments may attach health care financing obligations to employment, the advocates of any federal initiative that will be implemented via employer-provided group health plans must decide whether and to what extent to propose that state and local mandates be taken into account in defining an employer's federal obligations. At the same time, if ERISA does preempt state and local measures such as the San Francisco HCSO, the advocates of allowing the states

to function as laboratories for the improvement of health care delivery and finance would be required to include a cut-back on the scope of ERISA preemption in measures they advocate.

At best, the uncertainty over what the law currently allows in the way of state and local mandates will waste valuable legislative time and energy on debate over whether and how to limit state and local authority, or whether and how to accommodate its unpredictable future exercise in federal legislation. At worst, the uncertainty could impede the compromises, splinter the coalitions, and prevent the formation of the consensus necessary to enact any meaningful health care reform. This is so because the decision in *GGRA II* completely unravels the legislative compromises reached at the national level in 1974 that allowed Congress to pass ERISA. *Cf.* Michael S. Gordon, *Introduction: The Social Policy Origins of ERISA*, in Employee Benefits Law (S.J. Sacher and J.I. Singer, eds., ABA, 2d ed. 2000) at xc–cii (ERISA would not have been adopted if it had not been premised on preserving employer autonomy over plan adoption and plan design).

Thus *GGRA* II leaves Congress with an unpalatable choice if it wants to harness employer-provided group health plans successfully as an engine of national health care reform: it either must revisit the controversies surrounding ERISA preemption that it resolved thirty-five years ago while simultaneously trying to reconcile all of the contemporary issues that have made reform legislatively unobtainable until now, or it must abandon any hope of a nationally uniform solution to

what a national constituency clearly believes is a national crisis. Moreover, the conflict between the Ninth and the Fourth Circuits will act as an impediment to fashioning a successful bill regardless of whether it favors state employer mandates or leaves no room for them. Proponents of either position will be forced to guess which of the *GGRA II* or the *RILA* decisions represents the true state of the law in order to know whether their bills must contain a provision augmenting or reducing the scope of federal preemption under ERISA.

As the leading historian of ERISA has noted, giving ERISA broad preemptive effect was essential to its adoption. "The desire for federal preemption was a key factor – perhaps, the key factor – in creating the coalition that pushed ERISA through Congress." J.A. Wooten, *A Legislative and Political History of ERISA Preemption, Part I*, 14 J. of Pension Benefits 10 (2006). That compromise came only after a protracted, hard-fought battle that lasted many years. There is no reason to believe that the rematch forced on Congress by the decision in this case will be any less contentious than the original battle.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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